VA MISSION ACT:

IMPLEMENTING THE VETERANS COMMUNITY CARE PROGRAM

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WEDNESDAY, APRIL 10, 2019

United States Senate,

Committee on Veterans' Affairs,

Washington, D.C.

The Committee met, pursuant to notice, at 2:30 p.m., in Room 418, Russell Senate Office Building, Hon. Johnny Isakson, Chairman of the Committee, presiding.

Present: Senators Isakson, Moran, Boozman, Tester, Murray, Brown, Blumenthal, Manchin, and Sinema.

OPENING STATEMENT OF CHAIRMAN ISAKSON

Chairman Isakson. I call this hearing of the Veterans' Affairs Committee of the United States Senate to order. I appreciate everybody being here today. Dr. Stone, especially, thank you for being here, and your entourage that is with you. They are both far prettier than you are, so we are glad to have them to look at.

But we are glad to have our VSOs here and everyone else here to contribute to their hearing. I appreciate your being here. I want to thank the Committee members who are here and those that are coming, which will be most of the Committee.

It is really important issue--meeting. We are going to

be talking about the MISSION Act, going in place. The official date it goes in place is actually an interesting date. It is a historic day--June the 6th of this year. The other June the 6th, you will remember, was D-Day, so this is D-Day for the MISSION Act and D-Day for health care in the Veterans Administration, and this is a D-Day hearing, if we might have, to kick that off.

We promised a number of Democrats who came to me, asking me to have this hearing, that we would do it. A number of our members as well have sought it. Everybody wants us to be successful. We want the VA to put this one behind them, fundamentally change the service they deliver for the better, reliability for the better, participation for the better. So timely care to a veteran is the primary thing we are providing and we provide a mechanism to do that that is as efficient as possible and avoids a lot of the problems we had in the past.

I will tell you this, though. As one who was here when Bernie Sanders and John McCain were on the conference committee that produced the Choice Act, which was about five years ago now, they were trying to do what the MISSION Act does. The Choice Act did not work for a lot of reasons; many of them were intentional, not by the VA necessarily but people who did not like Choice or did not like the way we were doing everything else.

The MISSION Act is an amazing piece of legislation. It is comprehensive. It took a lot of testimony, as those of you who came to all of our meetings will tell you, but it worked, and we got the input of the veteran, we got the input of the professional, we got the input of the Veterans Administration, and we have a bill that I think has the opportunity to be a mainstream, positive from here on out.

We have no option but for it to be that. I will tell you this--we cannot fail. You cannot afford to take this opportunity and miss the draw. We have got to do it. And I am going to see to it that we do what our main job is on the Committee and that is to do oversight. We have done a lot of bill passing. We have changed regulations and we have changed laws. We have done a lot of that. Now we are going to do oversight. We want to make sure that the outcomes for the veteran are improved, as are the times they get seen, the chances they get to be seen, and the choices they get of who sees them. So I am very interested in seeing that take place.

Let me say one other thing. I am deeply troubled that we had two suicides in Georgia in the last eight days. We had another one in Texas two days ago, if I am not mistaken, and there may have been others. Although that number is not an extraordinary number, vis-à-vis the number we have in total every year, which is about 22,000, but it a lot. One

life lost is too many. This Committee and the VA have been doing an admirable job, a great job, on trying to address the problem.

I am really proud of this Committee because three years ago, when you called some of the hotlines around the country you got a busy signal, and that is not good on a hotline, or they would say, "Please leave your voicemail and we will call you tomorrow." Well, if you are in danger for your life, if you are at risk for your life, that was not to happen.

But the VA has done a marvelous job of getting its hotlines and its teleconnections as accessible to veterans as you possibly could, and most people--I am not a physician but I will tell you that everybody tells you that when it comes to the act of suicide that the quicker someone who is at risk can talk to a professional, and get to a professional, the return on them saving their life is tremendously better than if it takes a long time to do so.

So I want for us to continue to do what we have been doing by making access to these professionals as easy as possible, using the benefits of telemedicine, using all the other benefits possible. And what the VA has done is seeing to it it had the doctors available to meet that challenge. But we are sorry for the lives that were lost. We are sorry for the lives that were taken by the person that ended up

killing themselves, but we want to make sure that we do not lose focus on the follow--ending veteran suicide is everybody's issue for us. It is the Secretary's issue, everybody at VA is for it, and it is everybody's issue in the country, because suicide is a huge problem.

So those deaths did not go by me without noticing them, not has it gone by me that we have got a job to do as long as we are here, and that is to see to it that we do the best job possible of ending that, to all purposes.

And with that said I will turn it over to the Ranking Member, Mr. Tester.

OPENING STATEMENT OF SENATOR TESTER

Senator Tester. Thank you, Chairman Isakson, and I would also add to that that I believe those three suicides happened in the last week and all happened on VA property, and that makes it particularly gut-wrenching, and I think we will probably get into that a little more today.

Dr. Stone, thanks for being here. I appreciate your service and I appreciate you being here. One of these years I hope to get you confirmed, and it will be a good thing. And I appreciate you bringing the two docs to your left and your right with you too. I appreciate you guys' service also.

You know, this Committee worked hand-in-hand with the Administration and veteran service organizations when we

developed the MISSION Act. It was the result of compromise, it was a product of years of work, and it was because of the great leadership of our chairman, Chairman Isakson, that we were able to consolidate multiple VA Community Care programs into one streamlined program that makes sense for our veterans and for our community providers and for our taxpayers.

When the VA could not provide care in a timely manner the aim was to ensure that veterans could access quality care in their communities in a timely manner. In places like Montana, where the VA has failed to place enough emphasis on hiring physicians, the route to community care has always been critical.

But since the MISSION Act was signed into law I have had concerned that the VA's primary focus would be in supplanting in-house care, as opposed to supplementing that care when it makes most sense for our veterans. And the VA is doing so without the benefit of having completed thorough market assessments that would confirm what the community can and cannot actually offer. In our rush, in the VA's rush to open the private sector, my concern is that the VA is outsourcing its responsibility to ensure veterans receive--and this is what is really important in this whole MISSION Act thing--that they receive timely and high-quality care.

When the VA sends veterans into the community without

first knowing if that care can be provided in a timely manner it is outsourcing its responsibility, and when the VA sends veterans into community for care that would be of lower value, it is outsourcing that responsibility.

In writing, the MISSION Act intent was never to send veterans into the community for care that was less timely and of lower quality than the VA can provide. In fact, we have specifically required the VA to ensure that community providers could meet the same access standards the Department established for itself. But now we find that the VA is establishing one set of rules for itself and no rules for the private sector. I hope we get into that a little bit in today's hearing.

And it is doing so while knowing that, on average, VA outperforms the private sector in terms of timeliness and quality, and you need to be commended for that. Not to mention that the VA is doing this without a firm grasp on how much it will cost the American taxpayers, and it comes on the heels of the VA saying it would consider the performance if its facilities were making resource allocation decisions.

So on one hand the VA does not have a clear understanding of how much the program will cost, and on the other hand the VA openly states that it would make funding decisions based on whether its facilities are meeting the

standards it fails to enforce on the private sector. So what I see is behavior that smacks of a deliberate effort not to implement the best policy but to potentially carry out what I think is a political agenda.

Dr. Stone, I know that you are a straight shooter and there is no doubt in my mind that the policies you advocate for are with the best interest of the veterans in mind. But as the VA chief witness today, you will need to explain why the Department's access standards offer the best option for the veterans. I am not just talking about veterans who opt for the private sector. I am also talking about veterans who utilize VA care.

And you will also need to ensure the Committee that the program you are implementing will be ready to go on June 6th. Right now it is not clear whether the technology the VA needs to carry out this program, such as the decision support tool, will be ready for implementation. And not just ready for use but with the VA personnel appropriately trained on how it works. And if it is not ready to go, and folks have not been adequately trained, does the VA have a viable backup in place? The VA has had a full year to get this program up and running. If veterans are going to see a delay in care because the program is not ready to go, I think the best time to tell us that is today.

And I want to thank you, Mr. Chairman, for calling what

may be one of the most important VA Committee hearings this year, and I cannot thank you enough, Dr. Stone, for your patience and for you being here today. Thank you.

Chairman Isakson. Thank you, Senator Tester, and I appreciate your support throughout this process and I am glad our witnesses are here today, and I will introduce our first panel.

First is Dr. Richard Stone, Executive in Charge of Veterans Health Administration, and Executive in Charge is a pretty good title. It means the buck stops there. We are glad to have you here today to talk to us about the implementation of the MISSION plan, and we are particularly glad to have Dr. Kameron Matthews. Dr. Matthews, thank you for being here today. And we are glad to have Jennifer MacDonald--Dr. Jennifer MacDonald, VA MISSION Act Lead, L-e-a-d, which means you are at the head of the parade, the tip of the spear. So we are glad to have both of you here today to support Dr. Stone.

Dr. Stone, the podium is yours for five minutes, or more if you need it, because we want to leave here with all the information we have asked for.

STATEMENT OF RICHARD STONE, M.D., EXECUTIVE IN CHARGE, VETERANS HEALTH ADMINISTRATION, ACCOMPANIED BY KAMERON MATTHEWS, M.D., DEPUTY UNDER SECRETARY FOR HEALTH FOR COMMUNITY CARE, VETERANS HEALTH ADMINISTRATION, AND JENNIFER MACDONALD, M.D., VA MISSION ACT LEAD, VETERANS HEALTH ADMINISTRATION

Dr. Stone. Good afternoon, Chairman Isakson, Ranking Member Tester, and Members of the Committee. Thank you. Thanks for the opportunity to discuss the new Veterans Community Care Program under the MISSION Act. I am accompanied today by Kameron Matthews, who is the Deputy Under Secretary for Community Care, and Jennifer MacDonald, also a VA physician, who is the lead for the MISSION Act implementation.

The MISSION Act is an unprecedented opportunity to enhance veterans' empowerment over their own health care. Under the MISSION Act, veterans and their families will be able to choose the balance of VA-coordinated care that is right for them.

VA published regulations in February of this year with our proposed access standards for the new Community Care Program that will begin June 6th. These designated access standards implement eligibility criteria that will determine whether a veteran who is under VA's care is eligible for

care in the community.

The proposed access standards support VA's goal of putting decisions regarding health care in veterans' hands and making sure that veterans have access to care when and where they are needed.

VA's process for developing these designated access standards was not arbitrary. VA sought public written comment about the best design for this program and we held a public meeting to provide an additional opportunity for direct public comment. We carefully analyzed a wide range of federal, state, and commercial systems. We collected best practices and determined these standards with the best interests of veterans and their health care needs as the primary deciding factor.

From this process, the designated access standards we have proposed for Community Care under the MISSION Act are as follows:

For primary and mental health care, VA proposes a 30-minute average drive time standard, the same standard as is used in the TRICARE Prime and the same standard as is used by at least nine state Medicaid programs.

For specialty care, VA is proposing a 60-minute average drive time standard that is also the same as TRICARE Prime and multiple state programs.

VA further proposes appointment wait time standards of

20 days for primary and mental health care, and we propose also 28 days' wait time for specialty care. Veterans who cannot access care within these standards are eligible to choose either community providers or they may opt to continue to receive their care at a VA medical facility with their VA provider.

These access standards will guide veterans and their providers in making choices about receiving care in the community. Veterans will have more choices but VA will remain the integrator of veteran health care. Evidence has shown that even with more options veterans will continue to choose VA for their health care.

So while we increase veteran empowerment and choice we are continuing to invest in our direct care delivery system. The tools that you have provided under the MISSION Act ensure that high-quality direct care is readily accessible for veterans who choose it. VA's recent achievements in expanding access to health care are supported by new authorities under the MISSION Act that focus on our underserved facilities, recruitment, and the retention of our health care providers.

We are, in fact, the only health care system in the industry to make robust information about quality and access to health care fully transparent. Study after study has demonstrated that VA actually has shorter wait times, has

higher quality, and has higher customer satisfaction when compared to the private sector. VA also provides a nationwide system of VA health care providers who are experienced with and devoted to veteran-specific health needs.

We are committed to build the trust of America's veterans in VA health care, and we will continue to work to improve our patients' access to timely, high-quality care while providing veterans with more choice to access care where and when they need it.

Your continued support is essential to providing this care for veterans and their families. Chairman Isakson, Ranking Member Tester, this concludes my statements. My colleagues and I are prepared to answer any questions that you may have.

[The prepared statement of Dr. Stone follows:]

Chairman Isakson. Thank you very much, Dr. Stone, and I want to start out by turning to the Ranking Member and go ahead and let you go to the first question.

Senator Tester. Well, this is probably a question that you are as interested in as I am, Mr. Chairman. It deals with the issues of suicide, and particularly the issues that happened in this last week when we had three veterans commit suicide on VA campus.

Senator Moran and I authorized major mental health legislation last month to address the significant number of veterans who are suffering from mental health conditions and are dying from suicide. We believe that we need an all-hands-on-deck approach to addressing this problem, sooner rather than later.

So given these suicides that occurred on VA campuses, is there anything that is being done to make it easier for VA staff to recognize veterans in crisis outside the exam room?

Dr. Stone. Senator, there are--there has been more than 260 suicide attempts or suicides on our campuses. Two hundred forty of them have been interrupted and we have saved 240 veterans.

Senator Tester. Amen.

Dr. Stone. Unfortunately, more than 20 have been able to complete suicide on our campuses. Every one of these is

a gut-wrenching experience for our 24,000 mental health providers and all of us that work for VA.

Stopping suicide is not something that is going to occur just on our campuses, and as the President has signed the Executive order that places our Secretary in the lead for an interdisciplinary approach with all of American society to attempt to control this epidemic of suicides, we look forward to working on an interagency basis and with you.

But I would ask, with your forbearance, if we could just take a moment, and if you have got a cell phone in your hand, if you would take that cell phone out and put the following telephone number in--1-800-273-8255. 1-800-273-8255. That is the Veteran Crisis Line.

Now most lay people will say, "I do not know what to do if a veteran is in crisis. I am not a trained medical professional. What do I do?" Well, as a matter of fact, suicide often occurs when there is just intense loneliness. Picking up the phone and reaching out, or calling the Crisis Line, saying, "What do I do?" could stop a suicide and save a life.

I wish it was as simple as me saying I could do more patrols in a parking lot that would stop this epidemic, but some of those suicides have occurred with suicide notes saying "I have come here to the campus because I know you

will take care of me, and I know you will take care of my family."

Where have we failed that veteran? Where have we, as a community and society, failed that veteran is a very complex answer, but I would hope with these comments and for your-- thank you for your forbearance in allowing me to give the number out for our Crisis Line.

Senator Tester. No, I appreciate that, Doctor. I would just say that I do not think there is anybody that certainly serves in the Senate, certainly not on this Committee, that this is not one of the big issues that it is hard to find answers for.

And so as you are in your position, and the folks to your left and to your right are in their position, and this Committee, along with the Veterans' Affairs Committee in the House did some amazing work last Congress, is there anything else that you need from us to address the issue of suicide, and mental health, generally?

Dr. Stone. One of the things we need to be able to work our way through is three suicides a day occur in never-activated guardsmen and reservists. So they have never been activated to federal service so, therefore, are not considered a veteran.

Senator Tester. Right.

Dr. Stone. That usually occurs after age 30 and before

age 50, so their service may have ended a long time ago, but reaching never-activated guardsman and reservists is something that I think we need to talk our way through, of how we should view those. If we can take and extend emergency services to other than honorable discharges we sure ought to be able to offer those services to the never-activated guardsman and reservist.

Senator Tester. Great, Mr. Chairman.

Chairman Isakson. Senator Moran.

Senator Moran. Thank you, Mr. Chairman.

Chairman Isakson. Are you ready?

Senator Moran. I am ready.

Dr. Stone, thank you very much for your presence here on a very important topic. I appreciate and join my colleagues in concern about veterans who commit suicide and I look forward to working with the Chairman and certainly the Ranking Member on the legislation that we introduced. And I put Veterans Crisis Line in my iPhone, as you indicated. I never thought about it but it is an opportunity that if someone presents themselves to me I have someplace to go, and go quickly. So thank you for highlighting that for me.

I wanted to comment on something I heard you say just a moment ago, and I think it is pretty close to this quote. "Veterans will have more choices but VA will remain the

integrator of veteran health care." I think that is a desired goal on the part of all of us, and I thought you summarized the MISSION Act with those few words very well.

I remember the testimony of one of the representatives from the American Legion when we had our hearing over in the Visitors Center, and the point that he made on behalf of the American Legion was that care that originates with the VA, even if it occurs in the community, is still Veteran Administration care. And the importance to him of that was that the VA, and, therefore, Members of Congress but veteran service organizations, have control, someplace to go to when perhaps something is not quite right, that the place that we can still complain, even when something happens in community care, the VA is still in charge.

And in many ways the use of your word "integrator" again reaffirms what I heard this representative from the American Legion say about this issue of care in the community. The VA is still in charge. The VA is still the place we can go to influence something that is happening to a veteran that we care about.

So I would welcome any comment if you wanted to highlight anything more about that. If not, I will ask you a couple of questions.

Dr. Stone. Senator, I appreciate that. When I returned to the VA last summer people talked about

foundational services. What is foundational about the VA? To me, what is absolutely unique about the VA health care system is the lifetime relationship we have with our patients. And you are always a veteran, and we have got you for the whole lifetime, and we should be the experts in the complex disabilities that are caused by service.

We know, in our chronic living facilities and in our nursing homes, that over 50 percent of those patients have degenerative disease of the spine, hips, and knees with chronic pain. It is the VA that understands that, and therefore, even when we are buying care in the community we should be the integrator that brings everything together for that veteran.

Senator Moran. Thank you, Dr. Stone. Can you tell me at least some of the data that you utilized to determine drive times and wait times? What did you learn from the 2017 Merritt Hawkins Survey on wait times across 30 health markets? How did this information then help create the standards that will be utilized under your regulations?

Dr. Matthews?

Dr. Matthews. Thank you very much for that question. We did quite a broad-span market analysis. As Dr. Stone mentioned, we looked not only at public sector but also a fair number of commercial plans, state insurance departments, marketplace expansion plans, even Medicare

Advantage. All of these have wide-ranging approaches to network adequacy, and in general, how they build their services for their beneficiaries for their patients.

In looking at those numbers, we definitely saw some general trends, as well as then did a comparison of our own wait times and accessibility within our facilities and did that same sort of look at Merritt Hawkins, as you mentioned. Merritt Hawkins, of course, does a wide span of analysis in different metropolitan areas, some quite large like Boston, some smaller and a bit more suburban, if not closer to the rural side, and there is definitely not general trends of wait times across the board. So that was not really much to rest on.

So instead, by again looking at the different comparison of plans, what we were hoping to do was to stick with an industry standard so that our veterans, perhaps even used to the same sort of standards that they had through TRICARE, through even other private payers, might have an expectation, and one that is quite reasonable, about when they could actually receive care within a specific wait time or distance from their home address.

Senator Moran. So it is safe to say--I mean, I should be comforted by this, what you just said, I assume, because that means that decisions that are being made about what the access standards should be are based upon information across

the board from other health care providers and other networks to make certain we are doing as well or better on behalf of veterans, that there is a science, in a sense, behind the decisions that were made in access standards?

Dr. Matthews. That is accurate.

Senator Moran. I also hope that that means that we can better predict costs into the fair. Is that more than a hope? Is that more than an aspiration? It will improve the VA's ability to estimate its costs?

Dr. Matthews. That is also accurate.

Senator Moran. Mr. Chairman, my time has expired. I wanted to point out that Emily Wilson has been one of my staff members on veterans' affairs issues for the last four years, and this will be her last hearing, and I wanted to acknowledge her publicly, as a person who has cared greatly for veterans in Kansas and across the country, and has been an integral part of our work on this subcommittee. She is off to help folks at the Department of Defense and she will be missed. Emily, thank you for your service.

Thank you, Mr. Chairman.

Chairman Isakson. Thank you, Senator Moran.

Senator Murray.

Senator Murray. Thank you very much, Mr. Chairman.

Chairman Isakson. Senator Murray, let me interrupt for one second. I see a vote has just been called. Is that

correct?

Staff. I do not know.

Chairman Isakson. Not yet, or is about to be called?

Senator Murray. I will just ask two questions then.

Chairman Isakson. Well, no. I was just going to say, when it is, Senator Tester left to be there and then I will go replace him. We are going to keep the Committee meeting going.

Senator Murray. Okay. Great.

Chairman Isakson. Thank you.

Senator Murray. Thank you, Dr. Stone. Dr. Stone, the VA seems really eager to move forward with closing facilities but has so far been unable to explain what criteria will be used in making those decisions. VA has not described if or how it will make investments in improving or expanding care in the VA system, and this year's budget request certain does not prioritize that.

A fundamental principle guiding our work in this space since the original Choice Act is that expanding Community Care has to be done in tandem with investments in the VA health system. So I wanted to ask you, when will we see a comprehensive strategy to build and strengthen the VA system for the long term?

Dr. Stone. So part of the MISSION Act is that we provide to you, by the 6th of June, our first look at a

strategic plan. That strategic plan cannot be informed by our market area assessments because they will not be finished until midyear 2020. So although we have got 31 market area assessments currently to be completed, the next two waves of those market area assessments will not finish up for about a year.

Senator Murray. Well, what specific criteria are you actually using in evaluating the market assessments?

Dr. Stone. So there are more than 1,500 different data points to evaluate the markets, everything from the demand signal from our veterans, so how many veterans are going to live in a community, what is their age and what their predicted demand for health care would be, what their reliance on the VA will be. As you know, our veterans, about 80 percent of them, have other health insurance so they split between their other health insurance and us. Right now, about 38 percent of their care we provide, about 62 percent is provided by their other health insurance, on average.

So we will look at those data points. We will also look at the relative age of our facilities, what the potential investment needs to be, and are we in the right place? We talk about San Francisco. In San Francisco we have a beautiful site on top of a mountain but there is not a veteran in San Francisco in that area. They have to drive

about two hours to get to us. Are we in the right location?

Senator Murray. Okay. I understand that. If you could just get us what the specific criteria is so we understand how you are making these decisions.

Dr. Stone. So we are required by the statute, in publishing regulation that will lay all of that out, and we are required to share that with you before we publish them.

Senator Murray. Okay. I appreciate that.

I also wanted to ask you, a high-quality decision support tool is critical to the success of the community care program. So given VA's track record on scheduling I am very concerned that a manual process is going to result in widespread delays and mistakes, yet the U.S. Digital Service found some serious flaws in VA's development of the decision support tool, including that the VA did not even begin actively developing it until January. That is six months after the MISSION Act was signed.

USDS actually recommended scrapping the current decision support tool and making a different approach to address the most complicated eligibility criteria first, and they recommended ensuring veterans can see their eligibility themselves and for VA to create a process to resolve those disagreements.

Time is running out before the Community Care Program is set to launch, and I wanted to ask you if you have fully

implemented all of the U.S. Digital Service recommendations, and secondly, will the decision support tool that meets those recommendations be ready when the Community Care Program goes live?

Dr. Matthews. Thank you for that question. We definitely appreciated USDS's input with regard to the decision support tool. We are still moving forward with OINT's development of the tool. We have had multiple demos, including the interfaces that the decision support tool actually supports, and we actually have already started trainings on an online and virtual basis of providers in the field as well as program officer leaders.

So we do have full intend to have DST deployed by June 6th.

Senator Murray. Have you implemented all the USDS recommendations?

Dr. Matthews. No, we have not.

Dr. MacDonald. Senator, if I may add, we invited USDS to the table, the Department did, in an aim to have all of the talent available to veterans at the table to implement this with excellence and with an ease of these tools enabling these actions for our providers moving forward. We very much appreciated the devotion and the energy that they showed in doing the discovery sprint in a short two weeks time. It is difficult to understand some of the

complexities in our IT system. They brought a lot of expertise to the table that needed further discussion with our IT individuals.

That has taken place and we have learned and grown from the report. We have worked in collaboration with them to make sure that the tool we are delivering on June 6th is excellent and does save providers time such that providers, as we sit here and engage with veterans, that we have more time to focus on the veteran in front of us.

Senator Murray. Okay.

Dr. MacDonald. And, yes, training has begun, Senator.

Senator Murray. Okay. Thank you. My time has run out but I would like to include in the record the report by the USDS, Mr. Chairman.

[The report follows:]

/ COMMITTEE INSERT

Dr. Stone. With your tolerance, Mr. Chairman, let me just add one thing. You have got three doctors here talking about IT systems. That is probably dangerous.

Digital Services brought up some very interesting ideas on API interfaces that could lead us into a wave of the future. I think you are going to see a traditional approach to the first phase of this, for June 6th.

Senator Murray. Done by hand?

Dr. Stone. No. No, no. Traditional automated approach. But then there is an additional ability to integrate, that Digital Services brought up, that we would be happy to share with you, or our IT people share with you offline, that moves this to the next level and potentially gets us to a veteran-facing tool that might have huge value for the future.

Senator Murray. Okay. Thank you.

Dr. Stone. Thank you, Mr. Chairman.

Chairman Isakson. Dr. Stone, let me just interrupt for one second and then we are going to go to Senator Boozman. And if I am not correct, please correct me. But I was going to ask a question a little later. I have been waiting but you just prompted me to go ahead and ask one right now.

I was going to say, are you going to be ready June 6th to deliver the--what the MISSION Act asks for? Are you going to have all the tasks that you have been given done?

And from the answers you have given--you have given, as well as some others we received--the answer to that question already is no. And I do not say that negatively. I am just saying it sounds like to me you are at a sprint, and it is a big pill to swallow, and there is a lot to be done.

And one of those things in the VA is the technology issue, which you are all dealing with. And one of the great things people like me can do is complain about technology but I cannot do anything about it because I do not understand it.

Here is what I do understand. We have to respect the fact that there are technology programs. We learned from trying to make the Cerner decision the only way to fix that problem, in terms of medical IT, was to get a totally new system. The VA is populated with a lot of systems that we bought that are old and antiquated. Some are inoperable. Some with difficulties to do the tasks themselves.

Are you going to be able to be as functional as you want to be, given what you have got, given the resources you have, knowing that down the line you are going to have to get more equipment and better equipment to replace it?

And I am sorry for the long question but I wanted to--

Dr. Stone. Sir, this is as complex a legislation as you could possibly have. The automated systems to run Community Care require 11 different software systems, 10 of

which we have got in the field today. The 11th, the decision support tool, sort of brings them all together. Some were fielded as far back as last fall. Some we are fielding as we speak.

Are we going to get it all right? No. Are we going to deliver care on June 6th? Yes. The question is are we going to be as efficient as we should be? Are there going to be wait times that will grow because of this? We are confident that we are doing everything we possibly can to hit June 6th running.

Today we will deliver about 310,000 visits in our direct care system. We will also buy 50,000 visits today. On June 6th, our anticipation is those numbers will be about the same. So we will have about 360,000 contacts, or a third of a million contacts with veterans that day. We will get this right but we will get better every day. And I am not going to sit before you and say we are going to have everything right on June 6th. There will be something that does not go in the right direction and we have got to get corrected.

Chairman Isakson. And part of our job is to help you do that. I personally appreciate the thoroughness and the candor of that answer.

Senator Boozman.

Senator Boozman. Thank you, Mr. Chairman, and I want

to follow up on that. We do appreciate all of you and appreciate your hard work. We have got three excellent doctors here and you have got a bunch of Committee members that have been around for a while, and we have seen roll-outs in the past in the VA, and they have been kind of rough. In fact, we have seen roll-outs in government, period, in all kinds of different things, and they have been pretty rough also.

The problems is that the committees become the backstop, you know, in regard to pushing things along and providing the resources, you know, if we do have a problem.

So in Arkansas there is a lot of excitement about the MISSION Act. I have talked to countless veterans and VSOs, private sector health care providers around Arkansas. So there is a lot of looking forward to it. To be honest, they do not have much information yet.

And so I guess a question would be with the implementation only nine weeks away, what is the plan for engaging providers who are currently providing community care? Again, they do not understand what is going on. What is being communicated to them about the changes, and should they expect to see--what should they expect to see and the timeline?

Dr. MacDonald. Thank you for that question, Senator. Any change at this scale in a system our size must be taken

seriously, and at the core of our approach to the MISSION Act is, of course, veteran centricity but also the thought about our providers and our employees undertaking this change. We want to make sure that they not only have the tools in their hand that they need to implement this but that they have the knowledge and the awareness of the why of why we are doing this, that this is a new era of veteran empowerment, that they are able to sit down with a veteran, one-to-one, as we so as physicians, and say to that veteran, "I am able to help you make a choice that is in your best medical interest."

We have started communicating on that front. We have given the field a toolkit to use, and we have launched training as well on the key tools that are new to them, specifically the decision support tool. So just in this past month, and accelerating over the next couple of months, through and beyond June 6th, Senator, we will continue that campaign.

Senator Boozman. Okay. How about outreach to veterans? Are we outreaching? Do they know what to expect on June the 6th? Are we doing anything proactive in that regard to the veteran community?

Dr. MacDonald. Absolutely, Senator, and actually Section 121 of the MISSION Act directs us to do exactly that. We have developed a robust plan to reach veterans

across all eras and in various modalities as different eras may need. So not just through print materials, not just a poster in a facility, but also online and in other spaces that they may need information about VA and about the new benefits and care and services that they can receive under the MISSION Act.

We are also engaging, and very much appreciate our veteran service organization partners as they have offered to have several of their delegates trained such that that message and education can be amplified for the veterans that they encounter.

Senator Boozman. Arkansas is in Region 3 of the Community Care Network so we are impacted by the CCN contract that was awarded but is under protest. We understand that the VA has worked with the current third-party administrator to act as a backstop until the CCN contracts are up and running.

How will that impact veterans and providers in Arkansas? What is expected the current TPA, including terms of scheduling and processing of payments--when will the transition be complete and what, if anything, will change for the veterans and community providers between the original contract, the interim plan, and the new contract?

Dr. Matthews. Great question. A lot of information packed in there.

We are ecstatic that TriWest really stepped to the plate and became a partner for us nationwide, and through June, until such time as Region 3 in Arkansas and, of course, Region 2, as well, until such time as those contracts come out of protest, and, actually, until the new contract is deployed, TriWest will continue to stand by us as a partner, is working with us to modify their contract, to accept the new mission requirements so that there will be a seamless administration of this program, regardless of which third-party administrator we are working with.

There are differences between the Community Care Network contract, which is still pending, for Regions 2 and 3, and, of course, TriWest, but TriWest has really come to the plate to make them more streamlined, because, of course, their contract originally included the Choice Program. So we are quickly folding down the Choice Program in their contractual language, and again, the hope and TriWest's full intent is to make it as seamless of a transition as possible, when indeed that transition occurs to the next contractor. As of June 6th, TriWest will be offering services in Regions 2 and 3.

Senator Boozman. Good. Thank you very much, and we do appreciate your hard work. I think I can speak on behalf of the Committee, we really do want to help you. This is a huge undertaking and it is just going to take everybody

working together to get it done. Thank you.

Thank you, Mr. Chairman.

Chairman Isakson. Thank you, Senator Boozman.

Senator Blumenthal.

Senator Blumenthal. Thank you, Mr. Chairman, and I want to thank you for having this hearing, and, as usual, conducting it and the Committee in a bipartisan way, which is really the hallmark of the Veterans' Affairs Committee. So, as always, my appreciation.

This epidemic of veteran suicide is hardly new. You would agree with me, wouldn't you, Dr. Stone?

Dr. Stone. I would, sir.

Senator Blumenthal. And, tragically so, one of my first major pieces of legislation here, years ago, was the Clay Hunt Veteran Suicide Prevention Act, which I did with the late John McCain, Senator McCain of Arizona. And I am a supporter of the Tester-Moran act, the measure that has been proposed, and other measures. But the fact of the matter is that 20 veterans every day, in the greatest country in the history of the world, maybe more, continue to take their own lives.

And the mantra that we have heard from the VA, again and again and again, over the years, prior to your coming here, has been, "Well, they are outside the system. They are not part of the VA health care system," which, of

course, begs the question of "what are you doing to reach them?" That is why it is important that you stress the Suicide Prevention Line. That is why it is important that the VA use all of the resources, not just a fraction, that we have appropriated for outreach. Unfortunately, the VA, over the years, has failed to use those resources. And we had a hearing with Secretary Wilkie, when I think a lot of us expressed our profound dissatisfaction with that failure.

But the question is very pertinent today because in the MISSION Act a lot of veterans will be going outside the VA health care medical system, for lack of a better word. They will be going to non-VA doctors. The reason why they love the VA health care system is because it knows them. It is schooled and trained in how to care for veterans. And I can tell you about Connecticut. Our veterans deeply appreciate the quality of care that they receive in West Haven.

So my question to you is, assuming that a lot of veterans are now going to be going to other docs, what standards will be imposed to assure that those doctors are trained to recognize the symptoms of potential suicide--depression, post-traumatic stress? I may not be using the right scientific and medical language but I think you know where I am going with this question.

Dr. Stone. Sir, I appreciate the way you have characterized this because it is exactly the problem. There

is not another health care system other than the VA that understands the complexity of service or the fact that if you go down to the World War II memorial and you look at one of the hero flights it does not take you very long to pull the scab off of the traumatic events from 70 years ago of one of those veterans.

This is not something that we can simply give a course to a private physician, and it is why we must be the integrator of care. We can buy transactions of care, whether it be for psychiatric illness, we can buy a transaction of care, but the veteran needs to be integrated into our system for a full understanding of the complexity of these problems, and how difficult they are to care for, and that they are a lifetime problem.

Senator Blumenthal. And maybe the answer to my question--and I am just thinking out loud here--is to say that certain kinds of issues and challenges should be referred back to the VA health care system. If it takes 35 minutes or 65 minutes to drive to a VA facility, you know, maybe that is better than 15 minutes to someone who is going to say, you know, "You are waking up with sweats and anger? Take two aspirin and call me in a week."

Dr. Stone. I think you have characterized that well and that is why these discussions are best done between a provider and a patient, and then the best interest of that

patient is taken into effect.

If I might, and with your permission, Ranking Member Tester, we are in the process of recording local public service announcements. One of your members, Senator Sullivan, has taken advantage of that. I think the Chairman is also scheduled to do one of those. We would ask each of you to consider whether a public service announcement that we can reach out into your communities would be very helpful to us.

Senator Blumenthal. I will commit to do it right now.

Dr. Stone. Thank you, sir.

Senator Blumenthal. As many times and as often, as widely, wherever you would like to do it.

Dr. Stone. We will work with your staff and extend that same invitation to each of you, because your connections to your communities is what we need. And this is not just about the six that are engaged with us in health care. This is how do we reach the 14 that are not engaged with us, and we cannot just say, "Well, they were not in our health care system." We must be able to reach out. And this is the beauty of the President's Executive order, placing us in the centerpiece of trying to correct this across all 20 that are doing self-harm.

Senator Blumenthal. And just while I have you here I need to just say, although it is not directly related, when

Secretary Wilkie was sitting where you are in our last hearing I asked him about the West Haven surgical equipment processing facility, which he committed would be available, the mobile facility, by June. I hope that is still your expectation and your promise.

Dr. Stone. Sir, it is my promise. They have gone to two shifts. After our last discussion they have gone to two shifts a day of sterilization. I know they have struggled with their vendor to meet the June date. Their numbers are coming up. We are monitoring their numbers on a weekly basis. I know what I promised you and what the Secretary promised you. That is the right thing to and the veterans in that community deserve to be cared for where they want to.

Senator Blumenthal. Thank you, and I would just like to know if that date is going to slip that you let me know, because I will do some public service announcements-- unsolicited public service announcements for the vendors.

Dr. Stone. Thank you.

Senator Tester. [Presiding.] Senator Brown.

Senator Brown. Thank you, and because we are about 12 minutes into a vote I have two questions, two main questions for you, Dr. Stone. I am going to just read the questions and then have to leave to go vote. My staff is here and the record will reflect it. It is a little rude but it is the

only way I can figure out how I can do it, so thanks. Thanks to the Chairman and Ranking Member for doing this oversight hearing. It is really, really important.

We passed VA MISSION Act, as you know. It contained a comprehensive overhaul of the Community Care authorities into a new Veterans Community Care Program. We have tried to learn from our mistakes made in the Choice Program about arbitrary eligibility criteria relating to wait times and driving distances, all of which you know. We tried to provide veterans the best source of information for whether they should research Community Care consultation with their own VA provider.

Over 10 months, the VA has neglected to inform veterans and VSOs and Congress in the most transparent way, often limiting the information provided regarding resources and decisions. VA, in our mind, has failed to incorporate feedback from VSOs and health care providers prior to unveiling the proposed access standards a couple of months ago, in February.

By VA's own analysis, VA facilities scored 59 out of 100 when assessed for whether they could meet the expanded requirements set forth related to scheduling and care coordination. My office, like others, I assume, have received lots of calls and letters during the Choice Program related to scheduling and care coordination, as you know.

The questions are this. I would like to know how VA plans to meet veterans' needs and ensure that the proposed access standards do not lead to further privatization of the VA by pushing more veterans into the community because VA lacks internal administrative and medical capacity, and also explain how you plan to hold community providers to the same access and quality standards as the VA, per the MISSION Act requirements.

That is one set of questions, and I apologize for doing this. I wanted to follow up, though, after listening to Senator Blumenthal. We are concerned that the VA access standards, coupled with less resources for internal VA staffing, could, over time, lead to a hollowing out of VA facilities and, in turn, more Community Care. Our intent was never to have Community Care displace the VA, and I think there are some with the political philosophy in this body that would like to do that. It does not serve veterans. It certainly undermines what the VSOs want. Understanding many VA facilities provide exceptional specialized care, Senator Blumenthal and I worked on the Veterans Community in Section 133 of the MISSION Act, which stipulates that VA must establish competency standards, as you know.

So the other question I have is how will VA craft a program that allows veterans to go into the community when

deemed necessary by their provider without compromising or draining resources from the critical fields within the Veterans Administration?

So if you would just--the three of you take those questions. The general and Ann are here to listen and it will be reflected in the Committee report. So thank you so much.

Dr. Matthews. Thank you very much for that question. The first section of your question with regard to the readiness of our facilities to move forward with the changes, over the really last year and a half the Office of Community Care as well as operations in management have been working with facilities to assure that they are moving forward with the appropriate staffing that would be necessary to take back a lot of these scheduling and care coordination services. That requires, of course, hiring of staff over time, and the majority of facilities have done so.

As we moved away from the HealthNet contract, as many of you, I am sure, remember and wish to forget, we actually did see a swift uptake of a lot of those services by the facilities themselves. I mean, Ranking Member, your state alone has jumped into that task quite well, and the former HealthNet areas did indeed take up that challenge. There are a small number now, numbering 17, facilities that are

using TriWest to assist with scheduling for the short term. As they move into the new IT systems, with regard to automated referrals, automated authorizations, their workload will change and decrease, and indeed they will move away from having to do a lot of the administrative minutiae and focusing on that care coordination, scheduling for the veterans, if indeed that is what they request.

So we fully anticipate that the 17 sites will be moving away from the TriWest scheduling assistance by this summer, and as we deploy into the Community Care Network all facilities will be providing these services on their own.

The readiness score is really--the 59 out of 100 that the Senator quoted was a national average. We have that broken down at the facility level, even at the VISN level, so network directors are also accountable, and we are monitoring those on a weekly basis, just to assure, again, that their administrative services are coming up to bar, and we are seeing increasing scores across the board.

With regard to the competency standards that the Senator mentioned, Section 133 of the MISSION Act, of course, required that VA institute competency standards for community providers for veteran-specific conditions, specifically PTSD, military sexual trauma, and traumatic brain injury. We have been working with, of course, our renowned subject matter experts within VA.

We have those competency standards defined and we will be including those in the TriWest contract so that moving forward the network providers who, of course, treat those issues--so, of course, focusing more on mental health, just because of those named conditions, but also, in the future, contracts as well as Community Care Network deploys will be modifying those contracts as well. It is difficult to modify the contracts before they are actually awarded, so there is, unfortunately, a delay on how those will get implemented, because we would have to work with the actual awardee in order to do so.

But we fully expect that the third-party administrators help us enforce these competency standards, make sure, of course, that providers are meeting quality assurances as far as credentialing, but this additional specialty training and focus is necessary to treat veterans. We can see it as a continuation, of course, of our ability in the VA, but in a supplemental fashion, and so the requirement of these standards is well appreciated, and community providers are responding accordingly.

Dr. MacDonald. Additionally, on Section 133, we are providing general training for providers in addition to the specific PTSD, traumatic brain injury, and military sexual trauma training that will be provided for mental health providers. We are providing general training that

specifically elevates military culture and ensures that when a veteran chooses to be seen in the community that that community provider has a consciousness of what that veteran has experienced. Included in that general training, as well, is suicide prevention, yet another way we are aiming to amplify this message and ensure that even beyond VA, even beyond our direct system, that veterans are receiving the best care possible and that providers are well informed and able to respond when there is a need.

One additional note, to the Senator's question about the direct care and community care, and the equivalence of standards across both. We very much believe that in VA it is our responsibility to be in the lead on wait times and on quality. We see ourselves as one integrated system with a direct care aspect and a community care aspect.

It is our responsibility, as Dr. Stone has highlighted, to be the integrator of care across those two systems and to ensure that wherever a veteran is empowered to seek that balance of their care that is right for them that they are receiving that quality and timeliness, and, therefore, we aim to be in the lead and setting the standard for that.

Senator Tester. Before I go to Senator Sinema, a couple of things on the previous questions that I asked.

Dr. Stone, you brought up the fact that guard and reservists that had not been deployed do not have access to

the VA. I have got a bill that will fix that. It is S.711, I believe it is, and if we could get your support that, or your input on that, that would be much appreciated.

And the other point that I just kind of wanted to clear up before I move to Senator Sinema is that Dr. MacDonald, you had mentioned that the VSOs had been offered training opportunities on the tool. Which VSOs?

Dr. MacDonald. Senator, in breakfast with the VSOs who regularly join Dr. Stone we had a discussion about this and they actually, themselves, offered to have their delegates trained. I am happy to take that for the record and get you a specific list.

Senator Tester. That would be good and that way we can follow back with the VSOs if you have offered it and see if they have taken you up on it.

Senator Sinema.

Senator Sinema. Thank you, Mr. Chairman, and thank you for the witnesses and your testimony today.

As Americans, the blessings we enjoy every day are the direct result of the sacrifices that are made by our nation's veterans. And I was actually just reminded of this fact last month. I had the privilege of re-enlisting my little brother, Gunner's Mate First Class Sterling Sinema, into the Navy. And I am reminded that together we must ensure that our veterans receive the benefits and care they

have earned, including the quality mental health services and timely medical attention they deserve.

We know, particularly in Arizona, that veterans can carry the scars of service, both visible and invisible, for years after they transition into civilian life. And as the individuals responsible for providing care to former service members, I know each of you understand the incredible responsibility that you bear.

The MISSION Act represents the most deliberate and significant update to the veterans health system in decades, and I am committed to partnering with the VA to ensure that we get it right. And many of the problems the MISSION Act was designed to address, including the national wait time crisis, as you know, were first identified in my home state of Arizona.

Dr. Stone, Secretary Wilkie has already accepted my invitation, but I hope that you will also accept my invitation to visit our facilities in Arizona to ensure the VA's effort to implement the MISSION Act is successful. We want to address extended wait times but also include a plan to resource facilities that right now do not meet the new standards.

For instance, at the Hayden VA Medical Center in Phoenix the wait time for a new patient is 43 days, and in Kingman, Arizona, new patients are facing a 47-day wait for

services.

So I am interested in supporting policies that get veterans in front of medical providers faster, but the long-term health of the VA depends on providing the clinical and support staff, all the tools that they need to meet the standards that you all have set for them.

So, Dr. Stone, my first question is I know that you already agree that the overwhelming majority of the staff at VA medical centers in my state of Arizona are dedicating to ensuring that veterans get the care they need. But for the facilities that cannot currently meet the access standards that you all have established, how do you plan to provide the resources that clinical and support staff need in order to meet the assessment standards that the VA has established? And what percentage of existing patients will be eligible, under the wait time standards, and what percentage of eligible veterans do you think will choose to receive community care if those wait time standards are not met swiftly?

Dr. Stone. So let me take the easy part of that question, and that is, yes, I accept your invitation to come out to Phoenix.

Senator Sinema. Wonderful. Come soon. It is getting hot.

Dr. Stone. Thank you.

I think, secondly, we have taken a hard look at these wait time standards, as the Secretary has identified them. In some areas of the delivery system we are doing very well and in others we are struggling. Your communities are growing so quickly--

Senator Sinema. Yes.

Dr. Stone. --that we have had a very difficult time keeping up with the demand. And as you have identified, Senator, you know, it was Phoenix that was the centerpiece of what was wrong with our bureaucracy and our ability to respond to rapid growth. That community is still growing, at dramatic levels, and our ability to grow new space and new footprint is inhibited by a bureaucracy that can take us four to seven years to open a new footprint in leased space.

But let me defer to Dr. MacDonald who can talk a little bit about these access standards as well as sort of where we are doing well and where we are struggling and how we are approaching it.

Senator Sinema. Thank you.

Dr. MacDonald. Yes, and I will first highlight, Senator, that we have a core focus on primary care and mental health. In primary care, more than half of our facilities are meeting our wait time standards right now, but we intend for that to be all of our facilities meeting the wait time standards.

In mental health we are meeting that standard in 139 of 141 facilities, but again, 139 out of 141 is not enough. We want it to be 141. We want it to be everywhere such that every veteran has access.

The MISSION Act did give us new authorities and new ability to deliver on that promise, that we intend to provide across the nation, in every space, not matter how rurally or in an urban setting a veteran chooses to live. The MISSION Act gave us new ability for recruitment, retention, and relocation authority such that we can hire providers into areas where that has traditionally been challenging.

It also gave us, in Section 151, anywhere-to-anywhere telehealth, and we are pairing that with the underserved facility work that MISSION Act also requires, such that we have a comprehensive strategy to grow and build services in those facilities that have traditionally struggled to find providers.

In addition to that, there is a productivity initiative underway in VA such that we are maximizing and using every bookable hour of the staff that we currently have available. So on both aspects, the investment and productivity first, and the growth beyond that through the new authorities in MISSION Act, we intend to grow those services, no matter where a veteran lives.

Senator Sinema. I appreciate that response.

One of the concerns that we continue to see in Arizona is that, as you mentioned, Dr. Stone, and, Dr. MacDonald, as you also noted, Arizona is a particularly difficult place to meet those standards because of the rapid growth. And in our more urban settings, particularly in Phoenix, we have additional growth during the winter months by snowbirds who visit Arizona and seek their care at our facilities.

And one of the things we have struggled with is that we do not see an influx of additional staffing during those winter months but we see a huge increase in our percentage of veterans who want to receive care.

Right now, in Arizona, it is around 50 percent of veterans who even get their care from the VA, and if we see that continue to increase, which I know the VA is working to invite more veterans, particularly younger veterans to receive their care at the VA, but we also continue to have this influx of snowbirds, which will grow, not shrink, over the years, I think it would be wise for the VA to provide special consideration to communities that have unusual growth during certain times of the year, because of the nature of, well, living in the greatest state in the country.

Dr. Stone. I agree with you completely. It is one of the reasons that we have increased our funding in telehealth

so dramatically and why what you gave us in federal supremacy and our ability to really conduct telehealth across the nation, from any place in the nation, is so essential for us. You know, we have got about 750,000 veterans that took advantage of telehealth last year. We are going to get up to about 20 percent of our veteran population in order to respond to these demographic moves.

But it goes back to one of the opening questions that was asked by the Ranking Member--how do we approach the sustainment of the system? You know, I lived, early in my life, in a time where people lived in communities forever. They did not change. They were generational houses, from generation to generation. That does not happen anymore. We have to have the ability to follow where veterans are, and we are not very good at it. And there is a number of areas that we can discuss, well beyond the few minutes that I am over, sir, on this--in order to discuss sort of how to respond to these demographic moves that are so dramatic in your state.

Senator Sinema. I appreciate that.

Mr. Chairman, I have--my time has expired. If I might, just as I prepared to head to the floor to vote, I would also just want to emphasize the importance of ensuring that we are utilizing all the tools the MISSION Act gave for locality pay. In places like Kingman, Arizona, and our

Prescott VA Hospital, we are unable to recruit and retain the highest quality staff that we need because of the remoteness of the location.

And as you know, in Arizona, while 65 percent of our population lives in Maricopa County and has access to the Phoenix VA, the other individuals live so far away from these facilities that it is difficult to get to a VA facility, and it is incredibly difficult to find highly qualified individuals who want to work in those remote locations. So it is really important for us to ensure that these employees are compensated fairly to do the difficult work they are doing in these remote parts of our country.

Dr. Stone. Senator, you are right. I think you have given us the tools, though. I think the tools--not just locality pay but the enhanced educational loan repayment that you have given us all add to our ability to get this done. We are also deep in discussions with a number of medical schools, including the historically black colleges and universities, to support positions that might allow us to draw people in, and especially to the great areas of your state that need care.

Senator Sinema. Thank you so much. Thank you, Mr. Chairman.

Senator Tester. Thank you, Senator. A couple more questions and then we will get to the next panel.

Dr. Stone, we have talked before, and it has been talked about at this Committee meeting, about quality of care and timeliness of care. And I think in your opening statement you pointed out the fact that you guys keep track of that stuff, but a lot of folks in the private sector, it is hard to get that information. Would that be a fair characterization of what you said?

Dr. Stone. Sir, not to belabor my answer but it is a fair characterization, but if I might add--

Senator Tester. Yeah.

Dr. Stone. --I have great respect for our commercial colleagues.

Senator Tester. Absolutely. Yeah, yeah.

Dr. Stone. But they are not held to the standard that we are, nor--you know, a veteran can look at us pretty easily and figure out what is happening in our institution.

Senator Tester. So the question revolves around this, is that we are doing this whole MISSION Act for the sole purpose of timely quality care. And if we do not know that information it may be better for that veteran to stay with the VA care and have that appointment, even though it is past the 20-day period or the 28-day period.

When do you think you will know, as somebody who is going to integrate this health care, on how long it will take for the private sector to see a veteran, on average, so

you can tell the veteran, so that they are not thinking, "Well, I am going to go to the community care and get taken care of," when, in fact, they might have to wait longer than they would have waited if they had just stayed with the VA.

Dr. Stone. Right now wait times are not transparent across the nation and in the commercial sector. We will gather that data in real time.

Senator Tester. Do you have any idea when that data might--

Dr. Stone. In 180 days. About six months.

Senator Tester. About six months. Okay.

Okay. So let's talk about what happens when something goes wrong, okay. If you are at a VA facility, you file an 1151, and allows for compensation for injuries. It is fairly transparent and people know what is going on. When a veteran goes out in the community for care, something goes wrong--correct me if I am wrong--I think the veterans are on their own to seek redress, and if I am wrong you correct me on that.

Dr. Matthews. I would be happy to correct you, sir.

Senator Tester. Sure.

Dr. Matthews. We have actually instituted, over the last 12 months, a new patient safety structure that involves not only our traditional patient safety team in the facilities but the community care staff to work with our

third-party administrators to do the appropriate investigations and oversight of any issues that arise while a veteran is receiving care in the community. A lot of this, of course, hinges on the partnership with that provider. They may not be willing to share information. But moving forward we will be actually requiring that as part of participation in our relationships, contractually, that they take part in these patient safety conversations.

Senator Tester. Okay. So let's say something goes upside down in the private sector. What does a veteran do?

Dr. Matthews. A veteran definitely speaks either to their patient advocate, their primary care provider, reports it through any means necessary within the facility. The facility staff is trained to take that incident report and start initial investigation through the patient safety structure so that we can actually gather information to assure that that veteran is not facing harm.

Senator Tester. Okay. So if it is with the VA they can file a compensation claim. Can they file a compensation claim with the VA if something goes bad in the private sector?

Dr. Matthews. I would need to get back to you on that, sir. I would need to check our liability and all that.

Senator Tester. Or does the contract specifically state you can file the claim with the VA and the VA would

get the money from the person who screwed up?

Dr. Stone. Sir, we are going to get that for you, but I think you have got to go through the tort system. I think that this is--

Senator Tester. So they would be outside the VA.

Dr. Stone. I think so.

Senator Tester. The veteran would be outside the VA.

Dr. Stone. My impression--and we are going to correct this if I am wrong--

Senator Tester. No, no.

Dr. Stone. --but my impression is you have got to go through the tort system.

Senator Tester. And so I think that is also information the veteran needs to know, if something goes wrong. It becomes a little bit more complicated, in my opinion, but I am not a vet, but it sure appears that to me.

Well, look, I want to thank you all for being here. I certainly appreciate it. Sorry about the herky-jerkiness of this hearing with the votes going on, but it is the nature of the beast. Nothing personal, okay?

But we are going to stay in touch and make sure that we continue to be involved as you implement, and hopefully, as always, you will communicate back to us when you need help. This is a big step for the VA. I think we took a big step in Congress last year, and now we have got to make sure it

works. If it does not work then you and I are both in trouble, okay?

Thank you guys very much.

We will have the next panel come up. If you had anything to say, Dr. Stone, you can.

Dr. Stone. Just our thanks. Thank you, sir.

Senator Tester. Absolutely. And we will have the next panel come up and I will introduce you as we do the transfer.

[Pause.]

Senator Tester. So I have been told that they are waiting on the second vote so I think Chairman Isakson will be here as soon as they call that vote and he casts it and then whistles down here to the committee room.

In the meantime, I think we are going to get started with the statements, and I want to introduce the witnesses for Panel II. We have Sharon Silas, who is the Acting Director--I will let you guys clear first.

First we have Sharon Silas, who is the Acting Director for Health Care from the Government Accounting Office, otherwise known as the GAO. And then we have Adrian Atizado, who is the Deputy National Legislative Director for the DAV, the Disabled American Veterans. And we have Merideth Randles, who is a Principal and Consulting Actuary for Milliman.

I think we will start with you, Sharon, with your opening statement. I am not going to cut you off but if you could try to get it to five minutes then your entire written statement will be made a part of the record.

Thank you all for being here. We look forward to your statements.

Sharon?

STATEMENT OF SHARON SILAS, ACTING DIRECTOR FOR HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE

Ms. Silas. Thank you. Chairman Isakson, Ranking Member Tester, and members of the Committee, thank you for the opportunity to be heard today to discuss the findings from two of our reports on the Veterans Choice Program, the challenges that the VA has faced in implementing that program and the lessons learned that can help inform the implementation of the new Veterans Community Care Program, or VCCP.

Congress established the Choice Program in 2014 to address longstanding challenges with veterans' access to health care services at VA medical facilities. In 2018, Congress passed the MISSION Act, establishing the VCCP, which requires VA to consolidate the Choice Program with other Community Care Programs by June 6, 2019. GAO believes that VA's experience implementing and administering the Choice Program over the last four years can help inform the agency's implementation of the new VCCP.

Specifically, in 2018, we issued two reports and made a total of 12 recommendations addressing issues with the implementation and administration of the Choice Program. These reports offer a detailed review of the program and identify a number of operational and oversight weaknesses with the process for referring and scheduling veterans'

medical appointments, as well as ensuring timely payments to community providers.

First, in our June 2018 report, we identified numerous factors that adversely affected veterans' access to care through the Choice Program. For example, from the onset, VA's implementation of the program included an unnecessarily complex referral and appointment scheduling process that made it nearly impossible to meet VA's statutory requirement that veterans see a provider within 30 days when a clinician deemed the care was necessary.

Specifically we found that veterans could potentially wait up to 70 calendar days to receive care if staff took the maximum allowed time to complete the referral and appointment scheduling process established by the VA.

In addition to relying on an overly complex referral and appointment system, VA did not have enough trained staff, nor the tools, or the technology for the staff to efficiently coordinate and communicate across the program. The program also experienced insufficient contractor networks of community providers to meet veterans' health care needs.

Second, we found that VA could not systematically monitor the timeliness of veterans' access to care through the Choice Program because it lacked complete, reliable data to do so. The data limitations GAO identified included, for

example, incomplete data on the timeliness of processing referrals and authorizations for care, and inaccuracies with the dates used to measure the timeliness of care.

Although VA has taken actions to help address some of these issues we have identified, not all issues have been fully resolved. Based on these findings, we made 10 recommendations focused on improving VA's monitoring of access to care and wait times, more clearly communicating changes to policy and guidance, and facilitating seamless information sharing throughout the program. All 10 recommendations from this report remain open.

In September 2018, we also reported on the timeliness of payments of claims to Choice providers, which are important to guaranteeing that a sufficient number of providers participate in the contractors' networks.

Although VA has taken actions to address challenges related to paying providers, such as updating its payment system and educating providers on the claims processing requirements, we still identified concerns. For example, we found that 9 of 15 providers included in our review continued to experience problems contacting the VA to resolve medical claims issues. However, VA told us that they do not collect data on, or monitor contractor compliance with meeting customer service requirements. Based on this review, we made two recommendations that

continue to remain open.

VA has told us that they have taken steps to address all 12 of our recommendations in preparation for the implementation of the VCCP. However, many of those recommendations rely on the implementation of new IT systems and awarding six new contracts for the program, of which three have been recently awarded.

In summary, launching the VCCP in 2019 is a large and complex undertaking which comes with many risks and challenges. VA's experience with the Choice Program provides an opportunity to avoid the missteps made with the implementation of that program, and from the onset ensure that there are enough trained staff and the proper processes, policies, and technology in place to effectively monitor the VCCP and ensure that the program is providing veterans with timely access to care.

This concludes my prepared statement. I would be happy to answer any questions that you may have. Thank you.

[The prepared statement of Ms. Silas follows:]

Senator Tester. Thank you, Ms. Silas, and before I get to Mr. Atizado I just want to say--I want to thank Dr. Matthews and Dr. MacDonald for being here for this panel. Oftentimes agencies leave when a second panel comes in. It is important that you are here to listen, and so thank you for being here.

Mr. Atizado, you are up next.

STATEMENT OF ADRIAN ATIZADO, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. Atizado. Thank you, Senator Tester, Ranking Member Tester, Chairman Isakson, distinguished members of the Committee. First I would like to thank you for inviting DAV to testify at this hearing to examine VA's progress in implementing the Veteran Choice Program required by the MISSION Act. As we all know, it is due by June 6th.

DAV is a non-profit veteran service organization. We are comprised of over one million wartime service-disabled veterans, and today's hearing is critical for us and our membership because most of our members not only choose but they rely--if not most as well as entirely on the VA for care.

As you know, DAV worked closely with this Committee, with Congress, and VA in helping not only to craft but enact the VA MISSION Act, and we continue to believe that if fully and faithfully implemented, this landmark law will move us beyond just giving veterans choice, that it can and should empower veterans to make more informed decisions. But it appears VA's proposed rules may not achieve these goals.

Title I requires VA to be the primary provider and coordinator of care in a high-performing integrated network which combines the strengths of VA as well as the best of

which the community can offer. This is all, of course, to offer veterans seamless access to high-quality as well as coordinated care in a timely manner.

VA is making progress implementing Title I of the VA MISSION Act but with less than eight weeks before the new law is set to take full effect we do not believe that the new wait and drive time eligibility standards can be easily and efficiently implemented without serious risk.

We base our assessment on several factors that raise doubt, including VA's performance in successfully developing IT solutions on time, as well as the USDS--U.S. Digital Services--report on VA's compliance with Section 101 of the MISSION Act, VA's performance in implementing, operating, and improving the Veterans Choice Program, including GAO's reports on problematic weaknesses in the operation and oversight of the Choice Program, as well as VA's performance in accurately measuring wait times.

As my co-panel just mentioned, there is a misalignment with the timeline for transition to the Veteran Community Care Program with only three of the six regional contracts having been awarded. We have considered VA's proposed rule and its inconsistencies with the law and within the proposed regulations itself it is lacking several basic elements that are important to our veterans, especially as it is required by the MISSION Act. These are things such as requiring

private providers to meet the same time, same distance, and quality standards required of VA.

The proposed rule is insufficiently justified and uses assumptions that are far from reality. We have serious doubts VA will have the sufficient resources, staffing, and clinical space, as well as the executable plan to train and educate all those involved to have a smooth and successful transition to the new Community Care Program.

Simply, VA's proposed rules raise more questions than answers to us and leaves out critical pieces that would otherwise ensure veterans who meet the new eligibility standards are, in fact, able to receive timely, the highest quality, and coordinated care.

Weighing all these factors, we believe VA is not, nor will likely be sufficiently prepared within eight weeks without compromising some form of quality and risking unnecessary disruptions in receiving the care ill and injured veterans need.

Just to be clear, the majority of the law can and should move forward, particularly the urgent care benefit, expansion of the caregiver program, the improved organ donor and transplant program. Moreover, VA should move forward with other access standards required by the MISSION Act, as the grandfathered 40-mile rule when services are not available at the VA facility, when veterans experience

unusual and excessive burdens in traveling, and when it is in the veteran's best interest.

However, we believe this Committee must consider whether VA should withdraw the proposed wait and drive time standards or otherwise delay its implementation until VA has tested and certified that this new standard is not only feasible but sustainable, and that both VA and private providers can meet these standards together.

With what is at stake for ill and injured veterans across the country, we believe it is far better to get this right than to rush forward and play catch-up when things do not work.

Mr. Chairman and members of the Committee, thank you again for allowing DAV to testify at this important hearing. I would be happy to answer any questions you have.

[The prepared statement of Mr. Atizado follows:]

Senator Tester. Thank you, Mr. Atizado.

Ms. Randles, you are up.

STATEMENT OF MERIDETH RANDLES, PRINCIPAL AND CONSULTING ACTUARY, MILLIMAN

Ms. Randles. Good afternoon, Chairman Isakson, Ranking Member Tester, and distinguished members of the Committee. Thank you for the opportunity to discuss Milliman's role in the development of the Department of Veterans Affairs expenditure estimates associated with the MISSION Act Community Care access standards.

My name is Merideth Randles and I am a principal and consulting actuary with Milliman, an international firm of actuaries and consultants. Our firm is broadly acknowledged to be the leading consulting firm to health care insurers and providers in the U.S.

Health care utilization and expenditure projections are at the core of the actuarial consulting that we, as health care actuaries, provide to our clients. As a firm, we have served thousands of clients in the area of health care modeling through in-depth expertise around the specific needs, characteristics, and health care delivery environment of the population at risk.

I am a Fellow in the Society of Actuaries and a member of the American Academy of Actuaries. I began consulting with VHA in 1995, and was involved with the inception of the Enrollee Health Care Projection Model, VA's actuarial health care forecasting model, in 1998. This involvement continued

as the model became integral to VHA's budget formulation and strategic planning processes. I have supported VA in the valuation of a multitude of legislation, policies, and program initiatives, as well as briefings to governmental stakeholders.

VA's Enrollee Health Care Projection Model was used to estimate the cost for the MISSION Act access standards. This model is a health care demand projection model and uses actuarial methods to project veteran enrollment, utilization of VA health care, both specifically for VA facility and community care and the associated costs of that care.

The methodology underpinning the model is similar to approaches used by private health insurers, Medicare, and Medicaid. The model incorporates detailed demographic data specific to the VA Enrollee Health Care population, health care trends, economic conditions, and other drivers of change in the health care utilization and costs.

As the model was first developed in 1998, the current model is now informed by 20 years of VA experience, along with the expertise of VA's actuarian consultants at Milliman. The model is updated annually with emerging experience data and used to produce multiple enrollment, utilization, and expenditure scenarios each year. These scenarios are widely used by VA for important stakeholder needs, and the model now supports 90 percent of VA's medical

care budget.

The VA system is different from most health care programs in that, as referenced earlier, over 80 percent of veteran enrollees have other health insurance such as Medicare or employer-sponsored insurance. Therefore, VA is often called upon to provide only a portion of a veteran's health care needs. The term "reliance" in this context refers to the portion of enrollee's total health care need that they expected to receive through VA, at either a VA-operated facility or through community care, rather than through other health care sources.

Fiscal year '17 experience data indicates that through both VA facility care and community care VA provided 36 percent of the health care services used by enrollees, while other health insurance provided the remaining 64 percent.

Upon separation from the military, veterans navigate the U.S. health care system in a fashion similar to the general population, with the notable exception that they also have access to VA. Given this choice, current reliance levels are a testament to how many veterans value the care and services VA has to offer.

Every percentage point increase in reliance represents significant budgetary resource requirements. In estimating the impact from MISSION, we considered the experience of the Choice 40-mile enrollees. These enrollees received enhanced

eligibility to access care in the community, and, by definition, have limited geographic access to VA facility care, as compared to the average enrollee. Therefore, it reasonable to assume that enrollees eligible for similar access under MISSION's drive-time standards will have similar utilization and reliance behaviors.

Since 2015, ambulatory inpatient utilization has increased significantly for these Choice enrollees, and is expected to increase further. But I will emphasize that this utilization growth is for all VA-sponsored care, both within VA facilities and in community care. Further, utilization of VA facility care by these Choice enrollees has been stable and did not decline over this period. Finally, there have been no material impacts on enrollment due to the Choice Program.

I have provided extensive details regarding the actuarial methodology developed for the MISSION impact estimates within my written testimony, and I welcome your questions. Thank you.

[The prepared statement of Ms. Randles follows:]

Senator Tester. Thank you for your testimony. I thank all of you for your testimony. I appreciate it very much.

I think I am going to start with you, Ms. Randles, because actuaries are important.

When you did your projections, our third-party administrator in Montana, and in many other states that had the same third-party administrator, was nothing short of a train wreck. If there would have been a better third-party administrator I think the utilization would have went up.

Did you allow for--that is my belief as a farmer, not as an actuary, all right? So did you allow for any of those--that to impact your projections?

Ms. Randles. I think we allowed for it in so much as, as I alluded to in my testimony, when we study the experience of the Choice 40-mile enrollees since fiscal year 2015--

Senator Tester. Yeah.

Ms. Randles. --not only has their access in community care increased year over year, but it is not a situation where it increased the first year and plateaued. It is still on a pathway to increase, and we plan on that continuing into the future, during the next three fiscal years.

So what we think of as kind of enrollee response--

Senator Tester. Yeah. Got it.

Ms. Randles. --to the new program is continuing to have take-ups.

Senator Tester. Okay. And so when--are you aware what the VA has requested for their Community Care portion of their budget?

Ms. Randles. I am specifically aware with what I--the actual estimates that I provided to them.

Senator Tester. So that means you have got your estimates and they may be different from their budget.

Ms. Randles. Correct.

Senator Tester. Do we have your estimates?

Ms. Randles. I believe my estimates were included in my written testimony.

Senator Tester. Okay. Good.

Ms. Randles. One of the tables, yes, as well as in the RAA.

Senator Tester. Perfect. That answers my question. You do not need to go any further. Thank you very much.

Ms. Randles. You are welcome.

Senator Tester. Mr. Atizado, look, we know at the VA cares pretty darn good by all the studies that are out there. It is a pretty decent quality, I would say higher than the private sector. Is the DAV concerned that the VA is holding itself accountable for meeting the proposed access standards, but yet the private sector not so much?

Mr. Atizado. Certainly, Senator. You know, the thing we would like to avoid is not having this integrated network, which is really the foundation of the MISSION Act, right? If we do not have a network where VA and the community providers are actually working together, meaning working towards the same standard, what ends up happening is veterans may get better care in one place but not in the other, and that is not what we want. That is not what MISSION Act is all about. And so having a double standard is really--has so many adverse effects that can come of that that we would just like to avoid that altogether.

Senator Tester. All right. And so, you know, information is going to be critical on this. Are you concerned that many veterans may sign up for the Community Care and not understand that it may not be as timely or as good?

Mr. Atizado. So that depends on a couple of things, Senator, but yes, that is certainly a concern.

I mentioned earlier, in my oral statement, about wanting to make sure all parties involved in this evolution is educated and trained and understands how things are supposed to happen. One of those things is with regards to coordination of care.

Senator Tester. Yeah.

Mr. Atizado. I think this Committee is well aware of

the value of having coordinated care, but it is not regulated. In other words, VA did not propose how that is going to happen. It is such a critical piece of how VA delivers care that not to have it regulated, put in regulations to us, is, you know, an unfortunate oversight, and we would like to see VA correct that.

Senator Tester. Okay. I have got to scoot, but thank you guys. I have got to go vote, so thank you guys very, very much for your testimony. Ms. Silas, I did not get to you but we probably will later. Thank you.

Ms. Silas. Thank you.

Chairman Isakson. [Presiding.] I want to thank Senator Tester for burning more time than I intend to. We are not getting any cooperation out of our fellow members over there, and they are playing games, so we apologize for the delay. I appreciate the Ranking Member taking over as chairman for so long. Thank you very much--and you got all your questions answered?

Senator Tester. We got them.

Chairman Isakson. Okay. Good. And thanks to all of you, and I am so sorry that I missed your testimony and was not here when you made it, and I appreciate your being here and having--have you all been introduced appropriately?

Ms. Silas. Yes.

Mr. Atizado. Yes.

Ms. Randles. Yes.

Chairman Isakson. So you are not upset about your introduction. You are all happy. It was appropriate.

Well, I have two quick things and then I want to close, if I can. Number one, I want to thank Mr. Atizado and his organization for the amount of time they have put into the development of this program, the information that you have submitted before you testified today, your testimony that you have given today, which I did not hear because I was not here, but I have read, because it was provided to me earlier.

The VSOs are critically important to our entire veteran services that we provide as a country. I am trying to make sure your voices are heard and your interest is heard as much as possible. I have changed some of the methods that we operated under. I have not had as many panels with all the VSOs operating at one time but I have tried to make sure the most appropriate VSOs for each hearing testified like you have today, and I want to thank you for what you have done.

The other VSOs that are here, we are going to take their testimony in writing and submit it for the record, and be reviewed by all the members of the Committee. But our veteran service organizations are a tremendous voice for the veteran first, and for the country, and we appreciate so

much them doing it.

Now I am going to go to my two questions real quickly. One of them is a general question.

In the cases of many medical treatments that are provided by the VA--hearing aids, dental surgery, replacements, prostheses--so many different things that are covered, and there are many different medical devices that serve the same need that are made by different manufacturers, when you provide a prosthetic leg or a prosthetic titanium tooth, for example, for implants or whatever it might be, do you mandate how many choices there must be for the product that is used or do you have one certain--one that the VA approves? Or how do you go about that situation of making sure the veterans are exposed to the best possible equipment or device for the problem that they have, and whose choice is that, finally, about--if I am making good sense?

Mr. Atizado, I will start with you.

Mr. Atizado. Sure. Well, thank you for that question, Senator Isakson. As you know, when it comes to prosthetics items, let's just say for amputees, the prosthetic items that they end up selecting is quite individualized. There is a very intimate relationship between the prosthetist and the veteran patient.

Chairman Isakson. Right.

Mr. Atizado. They need to know both. They need to know where the veteran is having problems with, what they like and what they do not like, what they would like to see more, and the prosthetist has a responsibility to try and offer them the best solution or best prosthetic possible. And it not only goes from there. It tends to be quite a long relationship after that.

Chairman Isakson. Right.

Mr. Atizado. And so the decision really is a collaborative relationship between the clinician and the veteran, and that is critically important. Otherwise, we have got veterans going around having the wrong prosthetics can be quite--can have some quite terrible consequences for that amputated limb.

Chairman Isakson. Does anybody else want to comment on that question?

All right. Let me ask--yes, ma'am.

Ms. Silas. Go ahead.

Chairman Isakson. Okay. Let me ask a second question. I am 74 years old so I am in that age group where hearing aids are becoming a common need in a lot of cases. I have a 102-year-old mother-in-law, where my wife is today. My father-in-law passed away at 99 years and 11 months, was a World War II veteran. He had a hearing aid. And I have had more horror stories to tell about hearing aids than you have

got time to listen.

However, unlike a prosthesis, where you understand the differences because of the anatomy, a hearing aid is a hearing aid. But there are lots of different problems with hearing aids. Some of them you cannot find them. Some of them are too small to handle, all that type of thing. Is there any choices that you make for the veterans to choose from or do they get the hearing aid that the VA recommends, or you recommend as a provider? And I will let any of you address how we should do that, or how we do it.

Ms. Silas, any comment?

Ms. Silas. I was just going to defer to my fellow panelists, as I do not think I am in the best position to respond to the question.

Ms. Randles. I am not in a position to respond to the choice that the veteran is given. From the perspective of the Enrollee Health Care Projection Model, both for hearing aids and in prosthetics, we actively engage with the program leads within VA, each year and on an ongoing basis, to find out what kind of devices and trends are emerging, so they can be built into the forecast to appropriately account for those within the budget formulation.

Chairman Isakson. And that takes place periodically, as a function of the VA. Correct?

Ms. Randles. Exactly. With every annual model update

those conversations take place.

Chairman Isakson. Well, thank you very much.

Is there anything that you have not been asked or that you have not had the chance to say that you would like for us to know, from any one of these three panelists?

Yes, sir.

Mr. Atizado. If I could make one last comment, Senator. One of the things that I did not get to mention in my oral statement that I just glanced--that I glanced over in my oral statement but that is in our written statement, is the idea that veterans in this new Community Care Program, the idea of having an informed decision. One of the things that we were hoping VA would propose in its regulation is just that--what kind of information that veterans would like to see from this network so they can make the right choice, I think is what you are trying to drive at.

Chairman Isakson. Precisely.

Mr. Atizado. And there are a couple of things that our members, generally, or veterans generally, ask for. For example, if an elder, aging veteran who has complex chronic conditions wants to be seen in the community, the first thing I would make sure the veteran would want to know is that you probably want to go see a geriatrician, not just a regular primary care physician, because of their conditions.

So if there is not this kind of a discussion between a doctor, at the very beginning, as far as what the veteran should probably look for, then we are really doing them a disservice.

Now when they do find a specific doctor, there are a couple of things that patients like to see. I am sure everybody here would agree. They want to make sure that the doctor they are seeing is not only licensed but beyond that, that they have the training and competency standards to provide, say, for example, specific evidence advanced training that we know works for the condition that the veteran is going into the community for; that the patient knows interpersonal skills of the clinician. Are they good with the patients? Do the patients like the doctors? Does the doctor have good communication skills?

This basic information, as far as the patient or consumer would like to see, a sort of doctor scorecard. That is what we were hoping VA would provide our veterans when we wrote these provisions in the MISSION Act, about being able to compare and contrast between providers, not only in VA but comparing VA providers with private providers. Unfortunately, that is missing here in the proposed rule.

Chairman Isakson. I appreciate your comment. I think what you are talking about is not only having a choice but

making an informed choice. Is that correct?

Mr. Atizado. Yes, sir.

Chairman Isakson. Thank you very much for your testimony.

Senator Moran has not asked questions yet. Senator Moran, you are recognized.

Senator Moran. Chairman, thank you very much.

Ms. Silas, there was a 2018 GAO report that found the VA could not systematically monitor the timeliness of veterans' access to care through Choice because it lacked the reliable data to do so.

In a conversation in the appropriations process for Department of Defense, Vice Admiral Bono, who leads the Department of Defense Health Administration, said, "The DHA believes that these military health system-wide access standards ensure a consistent experience of care and access for beneficiaries," and that, quote, "different health systems must adapt standards that meet unique needs of the patients they serve. The specific standards we at DoD selected are perhaps not as important as the fact that the standards exist. We evaluate ourselves against the standards we set, and we share our performance with the people we serve."

My question is, do you believe that the MISSION Act's requirements for strategic planning for market assessments

and new access standards would help put the VA on a system--help create a system that--of consistent experience of care and develop more reliable and available data?

Ms. Silas. Thank you, Senator. I believe all of those efforts can make a difference, but I think based on the review that we did on the Choice Program, I think there are some additional actions that have to be taken to ensure that there is reliable data, including putting in processes that are not overly complex and putting out consistently comprehensive guidance and policies that the staff can be trained on, and communicating that information consistently throughout the program.

And then, lastly, putting in information technology to support the program. In our recommendations from our reports on Choice last year, as I mentioned in my opening statement, that all of our recommendations remain open and they are reliant on two key actions from VA. One is awarding all six of the contracts. The other is implementing the information technologies to support the program. And the two key systems--the decision support tool and the health share referral manager system--are estimated to be implemented later this year, but I think we need to wait and see if they make the schedule for that.

Senator Moran. Both of those recommendations, and the understanding that they are open, just as I--I mean, I

assume you would agree that just as they are necessary to improve Choice they would be necessary and helpful in improving the implementation and supports of care for veterans in MISSION.

Ms. Silas. Yes, sir. We conducted the work on the Choice Program, knowing that the program was temporary and would be ending and be followed by an implementation of a program--a permanent program. And so the audit work that we conducted for both of those reviews was doing that with that in mind, and our findings and recommendations were to provide opportunities, lessons learned, for VA so they could help inform the implementation of the new program.

Senator Moran. One of the things--and I would have asked the question--I had prepared to ask a question of the VA witnesses, had we not had votes and I had been absent--about the implementation of MISSION and what kind of information is being provided to the VA in the field.

Our case work certainly indicates that we get a certain direction from VA Central, but the folks who are implementing the decisions that have been made here, in Kansas, they do not know what the instructions are. And we have been encouraging the VA to provide a handbook, a set of very straightforward kind of conversation, for their employees, for the staff at the VA around the country, to better help implement MISSION Act. There is more than just

putting these regulations in place. How they are explained to veterans at home is a significant and critical piece.

Let me just quickly ask Ms. Randles, your modeling is not only a project for veteran enrollment utilization for VA health care but helps to inform the VA in strategic planning. Is this interconnected process valuable for modeling projections to--let me do this differently.

Mr. Chairman, I am out of time. Do you want me to finish this, or--

Ms. Randles, modeling for the MISSION Act. The cost impact of access standards is due to increased enrollee reliance, but I want to note what your statement says, and it was something--I think this is pretty close--care is not being transferred from VA facilities to the community. The cost is due to care that was previously paid for by other payers that the VA is now paying for, which I believe tells us that the MISSION Act is increasing reliance on the VA for care, both in-house and in the community, as opposed to Medicare or private insurance.

Is that something you were attempting to convey? And what I think the importance of that is--I mean, I saw this when we opened a CBOC, when the VA opened a CBOC in my hometown. The VA estimated that there would be 1,200 veterans who would access care at that CBOC. Within six months it was 2,400, double the amount. And the difference

was the VA estimated the number of veterans in that area of our state who would now, instead of going to Wichita, use the CBOC. What they never accounted for was the veterans who were not accessing care anywhere. And I think that is part of the point that you are making is that there are people who are getting care outside the VA that we are now bringing home to the VA.

Ms. Randles. Yes, that is correct. People who are getting care exclusively outside of VA but also part of their care, that over half of the veteran enrollees utilize the VA system in any given year, both VA and community care, as well as their other health insurance. And so the expansion of the MISSION estimates as an increase in reliance fulfilled through community care reflects an expectation that more of that care would come under the integration of VA in providing the care both within VA facilities in and in community care.

Senator Moran. And is there another sentence that would follow that, that would answer the question, and that is good?

Ms. Randles. Well, it certainly opens up access, in terms of more reliance indicates that VA is courting more of the care for the veteran.

Senator Moran. Thank you. Thank you, Chairman.

Chairman Isakson. Thank you.

Senator Manchin.

Senator Manchin. Thank you, Mr. Chairman. I appreciate hearing.

Chairman Isakson. Welcome.

Senator Manchin. I have some concerns, and my concern [inaudible off microphone] want to. That is what is out there and that is what I face every day, and I really have a high population base per capita. And there is no way in the world that I have any veteran wants to be privatized. They like the care they get at the VA.

Drive time--where is the song about West Virginia--Take Me Home, Country Roads. I can take you home 17 different ways, to your house, on a country road in West Virginia. One can take 35 minutes. One can take 20. One can take 45. But I will get you home. There is no standard set, and that is an $11 billion cost item, just to drive.

And we are rolling this out in less than eight weeks, and they are saying here that, you know, that some of the GAO recommendations you are implementing do not go into effect until later this year, but we are still rolling it out in eight week. I do not know what the hurry is. I do not know why we are pushing this. We have got--my goodness, we still have big issues with Choice and CareT and everything else.

I mean, my main thing is how can I get the best care to

my veterans? Anyway, I know that is in your heart too, or you would not be in these positions you are in. But I do not know if we are forcing something on you and telling you to go down this path, but I can assure that the veterans, and all the veteran representative groups are scared to death that this is basically the door opening to privatization, especially when 50 percent of the people can be affected by drive time. It makes no sense at all.

Anybody want to talk to that one? You can punt if you want to. I have got another one too.

Mr. Atizado. Senator Manchin, I appreciate your comments. I can certainly agree that our veterans in West Virginia love the VA. We understand that it is a very different--they present as very complex patients compared to the other veterans in the region. So your veterans in the state of West Virginia have very different needs, and so applying a general standard to a very different population can have some very undesirable results.

But I think the thing that I want to key in on your comments, Senator Manchin, is that I think veterans who choose to go to VA should be allowed the opportunity to be seen by VA, not say, "Well, I want to choose VA but since you cannot see me, well, you are going to send me outside." That is not really their first choice.

And so that is what we are really trying to focus on,

is that when they come to VA and want to be seen at the VA facility that they get seen at the VA facility, and not just say, "Well, since we are not meeting the standard that does not really apply anywhere else--"

Senator Manchin. With all this technology today the private sector is going to prey on our veterans like you have never seen. I truly believe that in my heart. That is a whole nother cash cow for them.

Mr. Atizado. I cannot speak to that, Senator Manchin, but I can tell you this.

Senator Manchin. Let me ask you this.

Mr. Atizado. If a veteran is to go to the private sector--I do not want to--I would like to make clear that DAV is not opposed to veterans going into the private sector.

Senator Manchin. Oh, no. I know we are not. We are trying to make sure they get the best care wherever they need it.

Mr. Atizado. That is exactly right, the best care, and that is what we are trying to focus on in this hearing, and in the regulations we proposed.

Senator Manchin. I am trying to say if we keep our veteran hospitals and our CBOCs and our clinics up to snuff, doing their job, they are going to get the best care right there. And what happens, we have allowed a lot of things to

fall below standards, showing that we cannot give them the care, and we have got to go outside into private care. That is what my concern is.

And here is the other thing. To me, managed care--we should be managing some of our--you know, some of our more sickly and more critical illnesses, to where they are getting that best care, specialized care.

I just--I am really worried about this, Mr. Chairman. I know that you have a tremendous population base also of veterans, and I do not know if you have heard it as much from yours, but I can tell you ours are very, very concerned, because now we are just starting to get some veteran CBOCs. We have got portable clinics. They are getting the care and they love it, and now they are going to say we are starting all over again. I do not know.

Do you want to jump in?

Ms. Randles. I would just reiterate, as I said before, from a data perspective, since the onset of the Choice Program, those enrollees who did become eligible for enhanced community access under Choice, the 40-milers, we have watched their utilization grow, both within the community but it has also been stable within the VA facility. So over this three-, four-year period their use of the VA facilities has been stable and has not declined. It has actually had a slight increase over this period as

well.

The other thing I would say is when we sort veteran patients into VA facility or Community Care they do not fall into one bucket or the other. The vast majority of the enrollees are utilizing VA facility care and Community Care services, paid for by VA, and coordinated by VA, during the fiscal year. So they are being served by both care delivery systems.

Senator Manchin. The other thing I wanted to touch one, which just adds to the concerns that we have, I understand there are 40,000 vacancies in the VA--40,000? What effort are we trying to do to fill those, or are we basically taking this approach because we cannot fill them?

Does anybody want to take that one?

I will give you one part. I am going to help you a little bit here.

Our CBOC in Parkersburg, okay, which is one of our larger little town, beautiful, on the river, the Ohio River, they are having a lot of trouble hiring and retaining providers, and it is hard for them, and all of my VA facilities, really, to compete with the higher salaries in other states, and we have not made those adjustments.

So, I mean, we are leaving--we are with a skeleton crew. We cannot give the services. We can justify they need to go to the private because they can get the better

care, because we are not paying competent wages.

Mr. Atizado. Senator Manchin, if I could tag onto that, I know your time is running. But first I want to--

Senator Manchin. We are okay. Answer this and then--

Chairman Isakson. I am actually enjoying what is going on with this.

[Laughter.]

Chairman Isakson. And I am going to take advantage of it in just a second. So you all go ahead and finish your little exercise.

Mr. Atizado. So I want to thank this Committee for taking a very bold approach in rolling back one of the key components that VA uses to help attract and retain and recruit highly qualified candidates, and that is what Senator Sinema was referring to when she was here, at the hearing. It was the recruitment relocation retention bonus program that VA has. That is a very important tool that recruiters have, across the VA health care system, when they see a good candidate, a strong candidate, a compassionate candidate, that wants to work in a VA and take care of our veterans. We are so thankful this can be past that and took that cap off. We are so glad this Committee gave the VA additional financial tools to help entice candidates to come in, whether it is debt reduction or scholarships.

Senator Manchin. Let me ask you that, on debt

reduction, because I have got an awful lot of my medical schools--I have got three medical schools, and I asked them all, I said, "Are they recruiting out with you all? Are they coming at you hard?" I have got nursing schools. Are you recruiting in nursing schools? They do not see the rapid, or the active recruitment going on.

So we might have put flyers out. We have might have done something but we have not actively gotten in and gone after--because some of these people want to reduce their debt. They want to bet out of debt, and they just--they are looking for ways of public service. And who knows? We might find people that really love the care they are giving and stay right with us. It is something we should be--there is so much more we can do.

Let me just say, about the Committee, though, our Chairman here. Our Chairman--this is going to be the best Committee you have got. It is the best Committee I serve on because it is bipartisan, truly bipartisan, because of our Chairman and our Ranking Member. All we care about--this is the one Committee that keeps us all together and bipartisan. It is the veterans.

But there are few that have a mindset that the private sector is always the way to go. That is except the type of care that a veteran deserves. It may be the private sector and does not have really the resources, or they do not have

the incentive for the return on investment that might come from a veteran that you might get in the private sector, so we have to be very care of that. So we are very cautious. I have not found a veteran yet that wants to go to private, but they will when they cannot get the care. And I am concerned that we are not giving the care because it kind of a back door, it forces them to go to private. That is the problem I am dealing with, which is hard.

Mr. Chairman, thank you for indulging me. You and I have a passion. I appreciate it, man. You have been going at this and I appreciate it.

Chairman Isakson. Well, I am glad you came and I am glad we closed with this exercise, and I want to comment on it. Is that all--

Senator Manchin. They are too.

Chairman Isakson. Yeah. Everybody--you know, the mind can only absorb what the seat can endure, and I think all of us have had enough of that for a while.

Anyway, I want to thank you for your comments and thank you all for being here. And let me make a couple of comments on the privatization deal.

I have been here since this whole thing started. This is my almost 15th year in the United States Senate. John McCain really kind of kicked off the idea of veterans' Choice when he was coming to the Committee, to get us to

address the subject, because veterans were having some problems. And, you know, we did not just create it out of the air because there was not a need. There was a need for more doctors to serve veterans. And at the time maybe we did it by making Choice available. We came up with a 30-mile rule--I mean, the 30-day rule and 40-mile rule and these other thresholds, and now we are getting a new rule for access, which is a 20-day rule and the 28-day rule, or whatever they are.

We tried to find those magic things to say, well, the veteran can go to the VA, or if they--Choice, if this happens, if they meet this criteria, and we can let them go to the private sector. And we had some bad experiences, which you are going to have with any big program, but we also learned a lot.

And I think we learned two things. One, we learned that we are not giving our VA hospitals and doctors and directors and VISN directors the money and the access they need to go out and recruit in the sector, and we were getting killed. And I want to thank you for mentioning--and you brought it up, Joe--what we did pass a couple of years ago, where they now have the ability in a lot of disciplines to go out and hire in a competitive manner, in the private sector, and that is great. We do have 40,000 vacancies in various places in the government because people do not want

to work.

And I would add, if we are always talking about privatizing something, I am not going to apply to work there if I do not know whether it is going to be public or private. So we are our own worst enemies sometimes if we talk too much about an alternative operations other than the one we have. And that is not a criticism. That is just a point to make.

The second thing is, I asked the question about hearing aids and other medical devices. I had a veteran who wanted to know if there is choice of somebody to provide the service they need medically but also provide what they need for their disease or their injury or their difficulty, to be better in the future than they are today. And that depends on--it is constantly looking at what is new to come, what is there to come, what they can bring new to our veterans. And you are never going to get the best of that unless you have some private participation as well as the VA.

But we are not going to privatize the VA. It is not my job to say we are or we are not. As Chairman of the Committee I cannot see any way you could privatize it, nor do I see any way you could treat our veterans by taking away the option of having a private choice. We have just got to make sure the private choice option they make is the best option for the veteran, and that we are doing the things we

have to do in running that system, to be sure the doctors that are paid in that system get paid, and that we are demanding the best out of both--our employees as well as the private sector--without discrimination, without prejudice, or without anything else.

And I think we can do that. I think the system wants to do that, and I think the attitudes within the VA are better today towards making ourselves better than finding some reason to put off doing this Choice thing because we do not like the idea of what it may become.

So I hear loud and clear the fear that people have, and I know what some say in the private sector. I also know veterans who say they have had bad experiences in the VA, and Lord knows we have had some of those as well. But I appreciate you bringing the point, and thank you for complimenting us on what we did as a Committee, and we are going to continue to try and do those things as Committee to give our tools to our VISNs, our hospital directors, and our other administrators, to figure out how to fill the vacancies we have got and hire the best people that we can.

So with that said, do you want to say something, Joe?

Senator Manchin. Yeah. I just wanted to follow up. You know, our affection for our dear, departed friend, John McCain, goes deep on both sides, very deep. The scandal that went on that caused all this to start, this dialogue--

you all remember that--and John was trying to react. We all react. We act very quickly. We were embarrassed by it and wanted to fix it. Sometimes we are not the best at fixing. We will overfix. And rather than getting rid of the bad apples and changing the system so you could not scam it and could not get bonuses and could not play the games they were playing, we went to a whole nother area, and that is where all this started.

I am going to give you a perfect example. In my VA hospital in Clarksburg, West Virginia, the Johnson Hospital, okay, an autoclave--an autoclave is what sterilizes the operating equipment. You would think that someone would know that this one is on its last leg, you ought to get another one. We went down and could not do any operations. Now you are telling me, how can that happen? How does that happen? And they would start sending them out to have the routine procedures done that we were doing right there.

We were doing another procedure for pulmonary exams. Private sector was charging us $700 to send them out and do pulmonary. We raised holy hell to get the equipment to do the exams in the VA. We were doing them for less than $100. We know we can do it, but for some reason--I do not know who is in charge of that--really, the audit and the equipment and the update and just the operation of these procedures, because that is what is happening to us, and that is the

biggest fear they have. They said, "Well, I need the care and I would like to get it at the VA but they do not have it anymore" or "This is not working."

Does that make sense? That is what we are working with, Mr. Chairman. That is what we are afraid of. If we can keep that up, and they have the best of Choice, which is truly a choice, if I can get the same service at the Woody Williams VA Center in Huntington that I can get at CMC, Charleston Medical Center, I am fine with that. I am fine with that. We are not giving them that choice because we are not staying up to speed.

That is my two cents. Thank you.

Chairman Isakson. Well, I appreciate the input and I appreciate your testifying today. And our job here is to make sure the VA serves the veteran but also serves the taxpayer of the United States of America, that they are getting the best bang for their dollar as well. And most taxpayers are also veterans so we are in good shape--or most of them are not veterans, but the 1 percent of them that are veterans deserve the very best choice, and this Committee is going to see to it that they get it.

But I appreciate the input we have had. We have got some challenges to go. I want to underwrite what Dr. Stone said. We are going to technically be ready by June 6th, but practically, because we all know that because of the

incumbent systems that are inherited, because of changes of technology that have to be made, lots of things we are going to have to do, to stumble before we walk.

But our goal is to walk and then run and do so successfully, and this Committee is going to support the VA, support our veteran service organizations. We are going to be the Dumbos of the whole Congress. We are going to listen to the suggestions that we get and make sure we are doing the best thing we can do for our veterans.

So on behalf of all the veterans in America and the people of the United States of America who send us up here, thank you all for participating, and be reminded that everybody has got five days--all members have five days to submit additional questions or additional information they want to go for the record. And unless there is any other business before this Committee we stand adjourned.

[Whereupon, at 4:34 p.m., the Committee was adjourned.]